CPS INFORMATION PACKET FOR CERTIFICATION

Program Name: _____ Certification Number: _____

INDIVIDUAL NAMES(S) He-M 507 APPROVED ONLY	SERVICE COORDINATOR

INDIVIDUAL NAME(S) ALL OTHER INDIVIDUALS

- **Please bring copies of returned NH criminal record checks, DMV, and BEAS Registry checks for all staff to the certification visit.**
- **Complete entire packet prior to certification. Incomplete packets with attachments will not be accepted.**
- **Attach copies of all fire drill evacuation reports dating back to last certification inspection. If an initial program, attach copies of all completed fire evacuation drills.**
- **When filling out the packet, please only use the original criminal record check and training dates from date of hire. Do not use updated training dates or more recent criminal record check dates.**

IMPORTANT: I swear or affirm that the information provided is accurate to the best of my knowledge and belief. I understand that providing false information shall be grounds for denial, suspension or revocation of the certification.

_____ _____

Signature and title of agency representative verifying that all information provided is complete and accurate **Date**

(If signing electronically, please indicate, "Electronically signed and dated")

MEDICATION INFORMATION

Certified Day Program Name and Certification Number	
Name and title of approved Nurse-Trainer, and Agency affiliation:	
Number of individuals in program:	
Number of individuals receiving administered medications:	
Number of individuals who self-administer their medications:	
Where is the medication stored?	
Name of licensed person responsible for Quality Reviews:	
Dates of quality reviews for the past year:	
Frequency of quality reviews:	

Name of Authorized Providers per **He-M 1201.06**	Current Authorization Date Range	Previous Authorization Date Range

Signature of Nurse-Trainer verifying information: _____ Date: _____

(If signing electronically, please indicate, "Electronically signed and dated")

Please attach copies of any He-M 1201 waivers

INDIVIDUAL MEDICATIONS

Individual's Name:_____Date of Birth:_____

Name of Medication	Dosage	Frequency	Prescribing Practitioner	Order Date	Reviewer ✓

_____

Full name and signature of person completing this form Date form completed

Provider/Staff Name	Date of Hire	NH Crim Check	BEAS	NH DMV	Auto Insurance	Annual Evaluation
		He-M 507.10(f)(2)	**RSA 161-F:49VII**	**He-M 507.10(f)(5)**	**He-M 507.08(g)**	**He-M 506.05(a)**

Training Information								
Staff/Provider Name	Date of hire	Rights Training	Overview DD/ABD	Quality of Life	Behavioral Support	Skill Building	Health & Safety	Self-Advocacy
		He-M 507.11(a)(1)	**He-M 507.11(c)(1)**	**He-M 507.11(c)(2)**	**He-M 507.11(c)(3)**	**He-M 507.11(c)(4)**	**He-M 507.11(c)(5)**	**He-M 507.11(c)(6)**

REVISED 12/23/13